

SECTION 5: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 6, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Winter Sport(s): _____ Spring Sport(s): _____

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address _____

Current Home Telephone # () _____ Parent/Guardian Current Cellular Phone # () _____

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent's/Guardian's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # () _____

Family Physician's Name _____, MD or DO (circle one)

Address _____ Telephone # () _____

SUPPLEMENTAL HEALTH HISTORY:

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

- | | |
|--|--|
| <p>1. Since completion of the CIPPE, have you sustained an illness and/or injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>3. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Since completion of the CIPPE, are you taking any NEW prescription or non-prescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any concerns that you would like to discuss with a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

No(s).	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date ____/____/____

**Tredyffrin/Easttown School District
Coaches Emergency Medical Information Card**

Student's Name _____ Grade _____ Date of Birth _____
 Parents' Name _____ Phone _____
 Address _____

Child resides with mother father both guardian (name _____)

In case of emergency please contact *(number in order of preference - local numbers preferred)*

Father's name/place of employment	Mother's name/ place of employment
Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____

Friend or relative

1. Name _____	Phone _____
2. Name _____	Phone _____
3. Name _____	Phone _____

Student's physician _____ Phone _____

*If emergency treatment is required, may school authorities use their own judgment to secure the services **of** the doctor most accessible if none **of** the people listed above can be reached? YES NO* Date: _____

Signature _____
(parent or guardian)

Authorization for Emergency Treatment of Minor

Consent

1. The undersigned is the parent/legal guardian of the minor identified.
2. This authorization is being provided to the Emergency Services Department for use in the event of the need for emergency treatment of the minor identified when neither the undersigned, the family physician nor the relative or friend identified can be reached to provide consent to treatment.

The undersigned hereby authorizes Physicians of the Emergency Services department or their designee (who must be a fully licensed Physician) to perform on the minor identified below, such emergency treatment or procedures as deemed appropriate, provided, however, that my consent or the consent of the family physician, friend, or relative identified will first be sought unless the delay in communicating with such person is, in the opinion of the physician, imprudent under the circumstances.

Minor's Name _____
 Health/Hospitalization Insurance _____
 Insurer _____
 Policy Number _____

Signature: _____

Medical history

1. Is he/she allergic to any drug, insect bite, food or any substance? Yes No If yes, explain.
2. Is he/she taking any medication? Yes No What and why?
3. Is he/she suffering from any condition requiring special attention such as asthma, diabetes, epilepsy; cardiac condition, etc.? Yes No What?
4. Has he/she been under the care of a physician or hospitalized in the past year? Yes No **If yes, when and why?**
5. Does he/she have any physical disability or handicap? Yes I No If yes, explain.